thrive chiropractic Unit 50-1580 Taylor Ave|Winnipeg|R3N 2A7 P. 204-504-life (5433)

PEDIATRIC HEALTH HISTORY

Today's Date: _____

Patient Data

Full Name: _____ Name of Parents: _____ Sex: ☐ M ☐ F
Address: _____ City: _____ Prov:_____ Postal Code: _____
Telephone: (Home)_____ (Cell)_____
Birth date: _____ (M/D/Yr) Age: _____
Name of Pediatrician: _____ Telephone Number: _____
Has your child received Chiropractic care before? ☐ Yes ☐ No
Manitoba Health Number (6 digits): _____ (9 digits): _____

About Your Child's Health

Main **goal** in consulting our office for your child:

- ☐ Correction and resolution of existing problem
- ☐ Prevention/Healthy check-up (Please skip to next section)

Main *reason* for consulting our office: _____

Did your child's complaint(s) arise from a *Motor Vehicle Accident (MPI)*? ☐ Yes ☐ No
If yes, date of injury? _____ Collision type (i.e. rear-ended) _____Claim #_____
Name and phone number of *adjuster*? _____

If complaint is due to an action or event, please explain:

_____

How long have they had this condition? ____ Days, ____ Weeks, ____ Months, or ____Years
Did the complaint(s) come on: ☐ Suddenly ☐ Gradually
Is the complaint(s) getting: ☐ Better ☐ Same ☐ Worse
If your child has pain, is it: ☐ Mild/dull ache ☐ Moderate ☐ Severe ☐ Throbbing ☐ Sharp/stabbing
Is the condition worse in the: ☐ Morning ☐ Afternoon ☐ At school ☐ At night ☐ Constant
Is the complaint: ☐ Constant ☐ Intermittent ☐ Worse with movement
Does the condition interferes with: ☐ Sleep ☐ School ☐ Walking ☐ Exercise ☐ Other_____

What seems to aggravate their condition/pain?

_____

What (if anything) relieves their condition/pain?

_____

If they have or are currently receiving other treatment, please describe type of treatment:

_____

Other Symptoms and Conditions

Has your child experienced any of the following:

☐ Headaches	☐ Ear Infections	☐ Back/neck pain	☐ Asthma/Allergies
☐ Colic	☐ Loss of balance/Fainting	☐ Chronic colds/flu	☐ Seizures
☐ Digestive problems	☐ Bed wetting	☐ Growing pains	☐ Sleep problems
☐ Recurring fevers	☐ Scoliosis	☐ Depression	☐ Autism
☐ ADHD	☐ Poor concentration	☐ Mood swings	☐ Other:_____

Please list any medications they are receiving:

_____

Please list any surgeries: (Type and date)

_____

Has your child had any of the following in the last year? ☐ X-rays ☐ CT Scan ☐ MRI

Events and Habits

In-Utero	Yes	No	Date and/or pertinent details
Complications during pregnancy?	☐	☐	_____
Falls or injuries to the mother?	☐	☐	_____
Medications used during pregnancy?	☐	☐	_____
Smoke or drink alcohol?	☐	☐	_____

Birth process	Yes	No	Date and/or pertinent details
Long/difficult delivery?	☐	☐	_____
Use of forceps/vacuum extractor?	☐	☐	_____
Caesarian section (planned or emergency)?	☐	☐	_____
Breach/cephalic?	☐	☐	_____
Mother given drugs/epidural?	☐	☐	_____
Induced labour?	☐	☐	_____

Childhood			
Any notable falls or sports injuries?	☐	☐	_____
Any significant illnesses?	☐	☐	_____
Any prolonged medications?	☐	☐	_____
Does he/she exercise regularly?	☐	☐	_____
Does he/she eat as healthy as they should?	☐	☐	_____
Healthy weight?	☐	☐	_____
Poor posture?	☐	☐	_____
Extended hours at a computer?	☐	☐	_____
Involved in any high impact sports?	☐	☐	_____
Take nutritional supplements?	☐	☐	_____

Sleeping posture ☐ Side ☐ Back ☐ Stomach

Exam and/or X-ray Consent

_____(initial) I hereby authorize/grant permission to Thrive Chiropractic to communicate with other health care professionals, insurance providers, and/or **MPI** (if applicable), and/or the **Worker's Compensation Board** (if applicable), with respect to my file or claim.

I _____, being the parent or legal guardian of _____, hereby grant permission for my child to receive a chiropractic evaluation, x-ray evaluation (if necessary) and subsequent treatments.

Signature (Patient or Guardian):_____ Date: _____